MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4840

CERTIFICATE OF DEATH

04828

1 (M)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Reeder Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick 1935-1
d. STREET ADDRESS: 810 N. Maple Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Virginia — Last: Anderson

4. DATE OF DEATH: Month: 4 — Day: 22 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10-21-1879

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Calvin Grove

14. MOTHER'S MAIDEN NAME: Kathleen Hankey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Albert L. Anderson, Brunswick, Md.

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arterio-sclerosis — Years
DUE TO (c):

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture of left hip. — **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☒ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Slipped on Bathroom floor

20c. TIME OF INJURY Hour: 6 a.m. p.m. — Month, Day, Year: 3-27 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) Brunswick (County) Frederick (State) Md

21. I certify that (I) (this hospital) attended the deceased from October, 1960 to April 22, 1961, that (I) (we) last saw the deceased alive on April 22 1961, and that death occured at 11:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: J Secondari M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: April 23 1961

22c. PHYSICIAN'S NAME (Type): JOSEPH SECONDARI

22d. ADDRESS: BOONSBORO MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4-25-61

23c. NAME OF CEMETERY OR CREMATORY: Park Heights

23d. LOCATION (City, town or county) (State): Brunswick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: G. Lee Fogle — **ADDRESS**: Brunswick, Maryland

25a. REC'D BY REGISTRAR DATE: APR 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4841 04829

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr. 55 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport RFD #2 (Rural)
d. STREET ADDRESS: (Rural) Williamsport Md RFD2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Gene; Middle: Lee; Last: Atha

4. DATE OF DEATH: Month: April; Day: 16; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16 1961

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months; Days; Hours: 2; Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: James Donald Atha

14. MOTHER'S MAIDEN NAME: Shirley Jean Shupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. James D. Atha — Address: Williamsport Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Premature birth 5 months
DUE TO (b): Pollyhydramnos
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7625

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/16 1961 to Same 19, that (I) (we) last saw the deceased alive on 4/16 1961, and that death occurred at 10:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David R. Brewer M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/17/61

22c. PHYSICIAN'S NAME (Type): David R. Brewer
22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: April 18-61
23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery
23d. LOCATION (City, town, or county) (State): Western Pike near Clearspring Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf
ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE APR 20 '61
25b. REGISTRAR'S SIGNATURE: Clarence S Kraus

2181192 X V 0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4842 — 04830

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr. 5 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Williamsport RFD #2
d. STREET ADDRESS: (Rural Williamsport Md. RFD 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Lee — Last: Atha

4. DATE OF DEATH: Month: April — Day: 16 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 16-61

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 1 / Min. 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Hagerstown Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: James Donald Atha

14. MOTHER'S MAIDEN NAME: Shirley Jean Shupp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. James D Atha Williamsport Md RFD #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 762.5 Premature Birth — INTERVAL BETWEEN ONSET AND DEATH: 5 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Polly hydramnos
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April 16 1961 to Same 19___, that (I) (we) last saw the deceased alive on April 16 1961, and that death occurred on 5:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David R Brewer M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/17/61

22c. PHYSICIAN'S NAME (Type): David R. Brewer

22d. ADDRESS: Clear Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 18-61

23c. NAME OF CEMETERY OR CREMATORY: St. Pauls Cemetery

23d. LOCATION (City, town, or county) (State): Western Pike Near Clearspring Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert L Leaf Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 20 '61

25b. REGISTRAR'S SIGNATURE: Cathy S. Kuns

2281193XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4843 04831

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boonesboro
c. LENGTH OF STAY IN 1b: 19 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Fahney-Keedy Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown 03
d. STREET ADDRESS: Summit Ave. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First Mary — Middle Elizabeth — Last Baechtel
4. DATE OF DEATH: Month April — Day 4 — Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 28, 1873
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hagerstown Wash. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Baechtel
14. MOTHER'S MAIDEN NAME: Sarah Jane McDowell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Fahney-Keedy Home Records, Boonesboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 2 1960, to April 4 1961, that (I) (we) last saw the deceased alive on April 4 1961, and that death occurred at ____ M. from the causes and on the date stated above.

22a. SIGNATURE: G.W. LeVan M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/5/61
22c. PHYSICIAN'S NAME (Type): G. W. LeVan
22d. ADDRESS: Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/7/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown, Maryland
25a. REC'D BY REGISTRAR DATE: APR 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4844 302 04832

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 106 So Locust St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHY Middle LOU Last BAKER

4. DATE OF DEATH: Month April Day 7 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 2 1961
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 5
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Durell Baker
14. MOTHER'S MAIDEN NAME: Delores M. Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Durell Baker 106 So Locust St (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CMO PREMATURE BIRTH LBD 1'14" — INTERVAL BETWEEN ONSET AND DEATH: 4/9/61
DUE TO
(b): PULMONARY HYALINE MEMBRANE — 12 HRS
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/7/61 19 to 4/7/61 19, that (I) (we) last saw the deceased alive on 4/7/61 19, and that death occurred at 6:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Young M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/8/61
22c. PHYSICIAN'S NAME (Type): Ralph F: Young M.D
22d. ADDRESS: Williamsport Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/8/61
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: APR 12 '61
25b. REGISTRAR'S SIGNATURE: Clifford S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4845 — 04853

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA - RURAL
c. LENGTH OF STAY IN 1b: 54 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BOONSBORO MD. R.1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BENEVOLA - RURAL
d. STREET ADDRESS: BOONSBORO MD. R.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSIE — Middle C — Last BAKER

4. DATE OF DEATH: Month APRIL — Day 1 — Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUGUST - 11 - 1878

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months 7 Days 20
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): KEEDYSVILLE WASH. Co. MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H. JONES

14. MOTHER'S MAIDEN NAME: MARY E. McNANIEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MRS. AUSTIN A. ROWE BOONSBORO MD. R.1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Hypertensive Cerebr-Vasc. Disease — INTERVAL BETWEEN ONSET AND DEATH: Aug 23-1957

~~DUE TO~~

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast.

(b): Cerebral Thrombosis — Jan 6-1961

DUE TO (c): Arterio - Sclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS ALTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 23 1957 to April 1 1961, that (I) (we) last saw the deceased alive on April 1 1961, and that death occurred at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Sidney Novenstein M.D.

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-3-61

22c. PHYSICIAN'S NAME (Type): SIDNEY NOVENSTEIN

22d. ADDRESS: FUNKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: APRIL-4-1961

23c. NAME OF CEMETERY OR CREMATORY: MANOR CEMETERY

23d. LOCATION (City, town, or county) (State): NEAR TILGHMANTOWN WASH. Co. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John R. East. ADDRESS: BOONSBORO MD

25a. REC'D BY REGISTRAR DATE APR 7 '61

25b. REGISTRAR'S SIGNATURE: C. Ellen S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. NOVENSTEIN

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4846

CERTIFICATE OF DEATH

04834

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Penna. b. COUNTY: Franklin

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 10 mo.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Jackson Convalescent Home

d. STREET ADDRESS: 136 S. Broad St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace; Middle: Haugh; Last: Barr

4. DATE OF DEATH: Month: April; Day: 25; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21, 1876

9. AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months; Days

IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY: - - -

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Cornelius Haugh

14. MOTHER'S MAIDEN NAME: Catherine Birely

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: - - -

17 INFORMANT Address: Miss Catherine Culbertson Waynesboro, Penna.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

I 2 0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Psychosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19___, that (I) (we) last saw the deceased alive on _____, 19___, and that death occurred at 2:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 4/25/61

22c. PHYSICIAN'S NAME (Type): Paul Harrison

22d. ADDRESS: 318 N. Potomac St. Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/28/61

23c. NAME OF CEMETERY OR CREMATORY: Green Hill

23d LOCATION (City, town, or county) (State): Waynesboro, Franklin, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE: APR 27 '61

25b. REGISTRAR'S SIGNATURE: Walter L. Klaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4847

CERTIFICATE OF DEATH

04835

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 7yrs 11 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d. STREET ADDRESS: 143 N. Artizan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elsie; Middle: VIRGINIA; Last: Beard

4. DATE OF DEATH: Month: April; Day: 2; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: January 22, 1867

9. AGE (In years last birthday): 94 yrs
IF UNDER 1 YEAR: Months: 2; Days: 10
IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Williamsport, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin VAN Buren Harsh

14. MOTHER'S MAIDEN NAME: Emily Catherine Snyder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: I, Gaver Beard — Address: Williamsport, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Generalized Atherosclerosis
DUE TO (c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cacheria

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug 19[illegible] to April 2 1961, that (I) (we) last saw the deceased alive on April 2 1961, and that death occurred at 4 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M E Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-2-61

22c. PHYSICIAN'S NAME (Type): M E Byrkit

22d. ADDRESS: Williamsport Md

23a. BURIAL CREMAT ON REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/4/61

23c. NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d. LOCATION (City, town, or county) (State): Williamsport, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — ADDRESS: Williamsport, Md.

25a. REC'D BY REGISTRAR — DATE: APR 4 '61

25b. REGISTRAR'S SIGNATURE: Clifton E. Mauck

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4848 04836

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 mo th
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Md. State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
d. STREET ADDRESS: 109 S. Hall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amelia Vere — Middle — Last: Benner

4. DATE OF DEATH: Month: April — Day: 10 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 24 1907

9. AGE (In years last birthday): 53 yrs — IF UNDER 1 YEAR: Months: 11 Days: 16 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Sharpsburg Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: George W. Mongan

14. MOTHER'S MAIDEN NAME: Helen M. Penner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 217 18 8975

17. INFORMANT: Mr. Ray G. Benner — Address: 109 S. Hall Street Sharpsburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): general carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO (b): Carcinoma of the ovary — 5 mos.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 175.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 17, 1961, to April 10, 1961, that (I) (we) last saw the deceased alive on April 10, 1961, and that death occurred at 10:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Victor L. Ramos, M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☑ — 22b. DATE SIGNED: April 10, 1961

22c. PHYSICIAN'S NAME (Type): VICTOR L. RAMOS, M.D.

22d. ADDRESS: Western Maryland State Hospital Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April 13-61 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery — 23d. LOCATION (City, town, or county) (State): Sharpsburg Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

25a. REC'D BY REGISTRAR DATE APR 13 '61 — 25b. REGISTRAR'S SIGNATURE: Victor L. Ramos

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4849 Iter 9 Firm G284 4/14/61 jwk

Reg. Dist. No. 14851

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clearspring R F D
c. LENGTH OF STAY IN 1b: ½ Hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Willsons

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clearspring R # 2
d. STREET ADDRESS: St Pauls
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ROGER — Middle LE ROY — Last BILLAN

4. DATE OF DEATH: Month April — Day 5 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 20 1908

9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor B. & O R.R. Retired

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hagerstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Billman

14. MOTHER'S MAIDEN NAME: Ida A. McCarty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 160-16-7564

17. INFORMANT — Address: Mrs Rose S. Billman Clear Spring R # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio Vascular Lesions — St Pauls — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: H. W. Dutton Jr M.D.

EXAMINER'S NAME (Type): H. W. DUTTON JR

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 4/6/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/8/61

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.

24a. REC'D BY REGISTRAR — DATE: APR 11 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4850 04838

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: PENNA — b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STATE LINE
d. STREET ADDRESS: STATE LINE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLOYD — Middle N. — Last BINKLEY

4. DATE OF DEATH: Month APRIL — Day 18 — Year 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/7/1892
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Franklin Co., Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Franklin Binkley
14. MOTHER'S MAIDEN NAME: Emma Brumbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NK (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 180-10-8657
17. INFORMANT: Mrs. Grace Meyers — Address: State Line, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Uremia + Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: about 2 wks

DUE TO (b): Hypertensive cardiovascular disease — 10 years(?)

DUE TO (c):

4427

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-25 1952 to 4-18, 1961, that (I) (we) last saw the deceased alive on 4-18 1961, and that death occurred at 10:07 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John H Hornbaker M.D.
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-20-61
22c. PHYSICIAN'S NAME (Type): John H. Hornbaker, M.D.
22d. ADDRESS: 154 West Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): B.
23b. DATE THEREOF: 4/21/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Greencastle, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: A.E. Mumich — ADDRESS: Greencastle, Pa.
25a. REC'D BY REGISTRAR DATE: APR 24 '61
25b. REGISTRAR'S SIGNATURE: Curtiss L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4851 — 04859

1. PLACE OF DEATH
a. COUNTY: Washington — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN Md.: 40 years — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 707 Salem Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — d. STREET ADDRESS: 707 Salem Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle JANE — Last BLACK

4. DATE OF DEATH: Month April — Day 27 — Year 1961

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: August 22, 1887 — 9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (County & State, or foreign country): near Luray, Virginia — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Price — 14. MOTHER'S MAIDEN NAME: Carolyn Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT: Mrs. B. Franklin Young — Address: Hagerstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Arteriosclerotic heart disease — 3 months

DUE TO (c): Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 16, 1961 to April 27, 1961, that (I) (we) last saw the deceased alive on Apr. 26, 1961, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John C. Stauffer — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John C. Stauffer M. D. — 22d. ADDRESS: Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/30/1961 — 23c. NAME OF CEMETERY OR CREMATORY: Keedletown Cemetery — 23d. LOCATION (City, town or county) (State): Keedletown Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — R. Franklin Rouzer — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 1 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4852

CERTIFICATE OF DEATH

303

04840

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 12 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 318 McDowell Ave

2. USUAL RESIDENCE (Where deceased lived If institution- Res dence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Hagerstown
d. STREET ADDRESS: 318 McDowell Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD Middle EVERINGTON Last BOWEN

4. DATE OF DEATH: Month April Day 6 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 23 1902

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fairchild Air Craft

10b. KIND OF BUSINESS OR INDUSTRY: Elec Inspector

11. BIRTHPLACE (State or foreign country): Wellsboro Tioga Co Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John R. Bowen

14. MOTHER'S MAIDEN NAME: Lary E. Rumsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 236-05-9538

17. INFORMANT: Address: Mrs Mabel S. Bowen 318 McDowell Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac decompensation — Interval between onset and death: 1 hr
DUE TO (b): Chronic myocarditis — 5 yrs
DUE TO (c): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 1922, to [illegible] 1961, that (I) (we) last saw the deceased alive on April 1961, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-7-61

22c. PHYSICIAN'S NAME (Type): J. D. Wilson, M.D.

22d. ADDRESS: 135 N. Potomac St, Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/61

23c. NAME OF CEMETERY OR CREMATORY: Verona Cemetery

23d. LOCATION (City, town, or county) (State): Verona Augusta Co Va

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 11 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4853 Item 8 Film G204 4/14/61 lwk 0484

1. PLACE OF DEATH
a. COUNTY: Washington (MARYLAND)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Cty. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Maugansville
d. STREET ADDRESS: North St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emory Middle: Eugene Last: Boyer

4. DATE OF DEATH: Month: Apr. Day: 9 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January ~~June~~ 28, 1929

9. AGE (In years last birthday): 32 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unable to work

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Maugansville, Wash. Cty.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pearre Boyer

14. MOTHER'S MAIDEN NAME: Anna Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mrs. Anna S. Boyer, Maugansville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years
4 4 2 X
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ...entally retarded since birth.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 5, 1961, to April 9, 1961, that (I) (we) last saw the deceased alive on April 9, 1961, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. E. Ditto M D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-10-61

22c. PHYSICIAN'S NAME (Type): Dr. E. W. Ditto, Jr.

22d. ADDRESS: 215 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/11/61

23c. NAME OF CEMETERY OR CREMATORY: Dunkard Cemetery

23d. LOCATION (City, town, or county) (State): Broadfording, Wash. Cty., Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4854 (14842)

M

X

I

1 PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL (If not an hospital, give street address) OR INSTITUTION [redacted] Frederick St.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greencastle 75
d. STREET ADDRESS Greencastle RD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH Month	Day	Year
	W.	MAYNARD	BROWN	April	25	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W		Dec 2, 1880	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Storekeeper + Farmer		Fulton Co., Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
David S. Brown	Catherine Ashwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	220-18-0956	Katherine Gordon [redacted] Frederick St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 151 X Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO (b) Adenocarcinoma Stomach — 3 years
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21 I certify that (I) (this hospital) attended the deceased from 2/14/61 19__ to 4/25/61 19__ that (I) (we) last saw the deceased alive on 4/24/61 19__ and that death occurred at 4:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22b. DATE SIGNED
Robert V. Campbell M.D.				4/26/61

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Robert V. Campbell	Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
B.	4/27/61	Pleasant Hill Cem.	Cearfoss, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
A. E. Mumma	Greencastle, Pa.	APR 28 '61	Carlton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4853

CERTIFICATE OF DEATH

04843

1 M

I

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 335 N. Potomac Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 335 N. Potomac Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAMUEL — Middle CARLETON — Last CLOPPER

4. DATE OF DEATH: Month April — Day 19 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 13, 1881

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Plumber
11. BIRTHPLACE (County & State or foreign country): Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William O. Clopper
14. MOTHER'S MAIDEN NAME: Susam Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-1751
17. INFORMANT: Dr. Evelyn C. Luke — Address: Hagerstown, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Ca of Prostate — Oct 1956
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: None 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, off ce bldg., etc.): None
20f. (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from April 17 61 19..., to April 19 ..... 19 61, that (I) (we) last saw the deceased alive on April 19 19 61, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: John D. Turco M.D.
22c. PHYSICIAN'S NAME (Type): Dr. John D. Turco
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STATE PHYS. ☐
22b. DATE SIGNED: 4-19-61
22d. ADDRESS: 302 N. Potomac St-Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/21/ 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county): Hagerstown — (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home
ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4856

CERTIFICATE OF DEATH

04844

1

M

I

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
c. LENGTH OF STAY IN 1b: 3 Weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hancock Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Little Orleans
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alberta — Middle: Tacy — Last: Creek

4. DATE OF DEATH: Month: 4 — Day: 15 — Year: 19-61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/11/1881

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): Matyland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred Creek

14. MOTHER'S MAIDEN NAME: Rebecca Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 215-14-6042A

17. INFORMANT: Scott M. Mann — Address: Little Orleans Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Cardio Vascular
DUE TO (c): Arterio Sclerotic disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/28 19 61 to 4/14 19 61, that (I) (we) last saw the deceased alive on 4/15 19 61, and that death occurred at p.m., from the causes and on the date stated above

22a. SIGNATURE: L M Shaffer M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. M. Shaffer

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/19/61

23c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist

23d. LOCATION (City, town, or county): Little Orleans (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard F Hose

ADDRESS: Hancock md

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4857

CERTIFICATE OF DEATH

04845

1 (M) (I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1708 Homewood Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1708 Homewood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Mae — Last: Crilly

4. DATE OF DEATH: Month: April — Day: 23 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 6 1895

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months: 10 Days: 16 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: George Reed

14. MOTHER'S MAIDEN NAME: Virginia (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Dr. Roy K Crilly — Address: 1708 Homewood Rd. Md Hagerstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY ARTERY OCCLUSION, WITH MYOCARDIAL INFACRTION — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO (b): CORONARY ARTERY ATHEROSCLEROSIS — UNKNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): DIABETES MELLITUS — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive arteriosclerotic Heart disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 8, 1950, to April 23, 1961, that (I) (we) last saw the deceased alive on April 22, 1961, and that death occured at 9:35 PM from the causes and on the date stated above.

22a. SIGNATURE: Archie Robert Cohen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/24/61

22c. PHYSICIAN'S NAME (Type): Archie Robert Cohen, M.D.

22d. ADDRESS: Clear Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 26-61

23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery

23d. LOCATION (City, town or county) (State): Williamsport Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf — **ADDRESS**: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 27 '61

25b. REGISTRAR'S SIGNATURE: Cirthur S. Krauss

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for Health Files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4853 Reg. Dist. No. 04846

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 215 E. Franklin St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 215 E. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: William — Last: Easton
4. DATE OF DEATH: Month: April — Day: 7, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 11, 1884
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Pangborn Corp.
11. BIRTHPLACE (State or foreign country): Greencastle, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Upton Easton
14. MOTHER'S MAIDEN NAME: Rebecca Lilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-09-6616
17. INFORMANT: Mrs. H. W. Easton — Address: 215 E. Franklin St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs
420.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. W. Ditto Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 4/9/61
EXAMINER'S NAME (Type): Dr. E. W. Ditto Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/10/61
22c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
22d. LOCATION (City, town, or county) (State): Hagerstown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.
Wm. G. Mont
24a. REC'D BY REGISTRAR DATE: APR 10 '61
24b. REGISTRAR'S SIGNATURE: [illegible] L. Frum

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4859

CERTIFICATE OF DEATH

04847

1 M

I

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4½ mos. (MARYLAND)
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Martin Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
e. STATE: Pa. b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chambersburg
d. STREET ADDRESS: 202 S. Second St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DELLA Middle: M. Last: ETCHBERGER

4. DATE OF DEATH: Month: April Day: 30 Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 18, 1883
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State or foreign country): Chambersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Carr
14. MOTHER'S MAIDEN NAME: Annie Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: -
17. INFORMANT: J.E. Etchberger Address: 244 S. 6th. St. Chambersburg, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia
DUE TO (b): Cerebral Hemorrhage
DUE TO (c): Senile arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 332 X

INTERVAL BETWEEN ONSET AND DEATH: 7 days / Recent / 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-10, 61, to 4-30, 1961, that (I) (we) last saw the deceased alive on 4-29, 1961, and that death occured at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): [illegible]
22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/2/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Grove Cem.
23d. LOCATION (City, town or county) (State): Chambersburg, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert B. Sellers ADDRESS: 297 Phila. Ave. Chambersburg, Pa.
25a. REC'D BY REGISTRAR DATE: MAY 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4860

CERTIFICATE OF DEATH

04848

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 3wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Penna
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairfield, Route 1 (Rural)
d. STREET ADDRESS: 7-X→
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Hagel — Middle: Amanda — Last: Eyler

4. **DATE OF DEATH**: Month: April — Day: 15 — Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1895

9. AGE (In years if under 1 day): 66 yrs — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sewing Factory

10b. KIND OF BUSINESS OR INDUSTRY:

11. PLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Kipe

14. MOTHER'S MAIDEN NAME: Nettie Harbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-05-9352

17. INFORMANT — Address: Robert J. Kipe, Fairfield Pa. R.D#1

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5-7 days

DUE TO (b): Parkinsons Disease — 5-10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Mar 19 52 to April 15, 19 61, that (I) (~~we~~) last saw the deceased alive on 12 April 19 62, and that death occured at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Harry Hyoungs M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-17-61

22c. PHYSICIAN'S NAME (Type): HARRY H. YOUNGSTER

22d. ADDRESS: Blue Ridge Summit, Pa

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 18, 1961

23c. NAME OF CEMETERY OR CREMATORY: St. Jacobs Reformed

23d. LOCATION (City, town or county) (State): Fairfield, R.D.#1, Liberty Twp. Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson — ADDRESS: Fairfield, Pa.

25a. REC'D BY REG STRAR DATE: APR 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

C. E. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4861 0484

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 48 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 146 South Locust Street

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 146 South Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELMER Middle DAVID Last FLORY

4. DATE OF DEATH: Month April Day 8 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 30, 1886
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Fairchild Aircraft, Waynesboro, Franklin Co.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Adam Flory
14. MOTHER'S MAIDEN NAME: Elizabeth Hunsberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ---------
16. SOCIAL SECURITY NO: 214-09-4950
17. INFORMANT: Mrs. Mary P. Flory
Address: 146 S. Locust St. Hagerstown, Wash. Co. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Coronary Occlusion with Infarction	Min
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	coronary Ischemia	5 days
DUE TO (c)	Coronary Atherosclerosis	yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 1957 to April 8, 1961, that (I) (we) last saw the deceased alive on April 6 19 61 and that death occurred at ____ M, from the causes and on the date stated above.

22a SIGNATURE: Louis G. Graff M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Louis G. Graff, M.D.
22d. ADDRESS: 119 E. Antietam St.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/11/61
23c. NAME OF CEMETERY OR CREMATORY: Shiloh E.U.B. Cemetery
23d. LOCATION (City, town, or county) (State): Security Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE APR 12 '61
25b. REGISTRAR'S SIGNATURE: Clara L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 9/59

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4862 (14850)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: WASHINGTON — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) — a. STATE: Penna. — b. COUNTY: Franklin ✓
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Greencastle
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Memorial Conv. Hospital — d. STREET ADDRESS: RD3 - Greencastle, Pa. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
09

3. NAME OF DECEASED (Type or print): First: Frederick — Middle: Speck — Last: FOX
4. DATE OF DEATH: Month: April — Day: 11 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/30/1881
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter — 10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Franklin Co., Pa.
12. CITIZEN OF WHAT COUNTRY?

(I)

13. FATHER'S NAME: Jacob Fox
14. MOTHER'S MAIDEN NAME: Lillie Speck
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 204-01-3157
17. INFORMANT: Galen Fox — Address: RD3 Greencastle, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs.
331 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Sept. 30, 1960 to April 11, 1961, that (I) (we) last saw the deceased alive on 4/8/1961, and that death occurred at 2:15 A.M. from the causes and on the date stated above

22a. SIGNATURE: David R. Hess M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): David R Hess
22d. ADDRESS: Shady Grove, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/14/61 — 23c. NAME OF CEMETERY OR CREMATORY: Prices Cem. — 23d. LOCATION (City, town, or county) (State): near Waynesboro, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: A.E. Mummert — ADDRESS: Greencastle, Pa.
25a. REC'D BY REGISTRAR DATE: APR 12 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

VR A15 (4) ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4865 Reg. Dist. No. 04851

1. PLACE OF DEATH
a. COUNTY: WASHINGTON MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SHANKTOWN
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): NONE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SHANKTOWN X
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First RALPH Middle RAYMOND Last GEHR

4. DATE OF DEATH: Month APRIL Day 20 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MARCH 14, 1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months 1 Days 6
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): INDIAN SPRINGS, MD.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DANIEL GEHR
14. MOTHER'S MAIDEN NAME: ELLA STEELE GEHR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: RALPH N. GEHR Address: BIG POOL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	Instant
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic Heart Disease	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Dr. W. A. Dido, Jr.
DATE SIGNED: 4-21-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: APRIL 23, 1961
22c. NAME OF CEMETERY OR CREMATORY: SHANKTOWN CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature]
ADDRESS: CLEAR SPRING, MD.
24a. REC'D BY REGISTRAR DATE: APR 26 61
24b. REGISTRAR'S SIGNATURE: Esther L. Rinard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. [redacted] should be forwarded to the Office of Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4864 — 14852

1 PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: JACKSON CONVALESCENT HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND. b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BOONSBORO
d. STREET ADDRESS: 1 POTOMAC ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID. Middle GARFIELD Last GILBERT
4. DATE OF DEATH: Month APRIL Day 25. Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 13. 1881
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months 5 Days 12
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: GENERAL STORE
11. BIRTHPLACE (State or foreign country): BOONSBORO WASH. CO. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: GEORGE W. GILBERT
14. MOTHER'S MAIDEN NAME: KATE LAKIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS. LLOYD THOMPSON Address: BOONSBORO MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis — Indefinite
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I)(this hospital) attended the deceased from April 24 1961 to April 25 1961, that (I)(we) last saw the deceased alive on April 24 1961, and that death occurred at 1:10A M, from the causes and on the date stated above.

22a. SIGNATURE: B. B. Kneisley M.D.
ATTENDING PHYS. X ☐ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/26/61
22c. PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington Street Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APRIL-27-1961
23c. NAME OF CEMETERY OR CREMATORY: BOONSBORO CEMETERY
23d. LOCATION (City, town, or county) (State): BOONSBORO WASH. CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Rust
ADDRESS: BOONSBORO MD.
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4865

CERTIFICATE OF DEATH

04853

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 15 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 106 North Ave

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 106 North Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle LAY Last GREEK

4. DATE OF DEATH: Month April Day 23 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 22 1875

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pa. Seward Westmorland Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Rogers

14. MOTHER'S MAIDEN NAME: Annie Cook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Marie G. Shields 106 North Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 9 yrs.
DUE TO (c): ___

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a. m. p. m. Month, Day, Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1946 19___ to 4.23.61 19___, that (I) (we) last saw the deceased alive on 4.19.61 19___, and that death occurred 7.00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: S. Earl Young M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4.24.61

22c. PHYSICIAN'S NAME (Type): S. Earl Young M.D.

22d. ADDRESS: 148 N. Potomac St., Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/26/61

23c. NAME OF CEMETERY OR CREMATORY: Brush Creek Cemetery

23d. LOCATION (City, town, or county) (State): Manor Westmorland Co Pa.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md

25a. REC'D BY REGISTRAR DATE: APR 25 '61

25b. REGISTRAR'S SIGNATURE: Cinthia S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4866

CERTIFICATE OF DEATH

Reg. Dist. No. 04854

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Farhney-Keedy Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodlawn
d. STREET ADDRESS: 6419 Windsor Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Effie — Middle: J. — Last: Grossnickle

4. DATE OF DEATH: Month: April — Day: 24, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 1, 1877

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Carroll CO., Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: David Cover

14. MOTHER'S MAIDEN NAME: Laura J. Lindsay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs. Joshna H. Armacost, Mt. Wilson, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Fall

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: May 1960

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Woodlawn, Baltimore, Md.

21. I certify that I attended the deceased from Apr. 21, 1961, to Apr. 24, 1961, that I last saw the deceased alive on Apr. 24, 1961, and that death occurred at 5:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B B Kneisley M.D. — ADDRESS (Street, city or town, state): 148 West Washington St. — DATE SIGNED: 4/25/61

PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D. — Hagerstown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-28-1961

22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: C. M. WALTZ, WINFIELD, MARYLAND

24a. REC'D BY REGISTRAR — DATE: APR 27 '61

24b. REGISTRAR'S SIGNATURE: Clinton S. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4867

CERTIFICATE OF DEATH

04855

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Jackson Convelascent Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 81 S. Potomac Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: M. — Last: Grove

4. DATE OF DEATH: Month: April — Day: 5 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: March 31, 1876

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months: 0 — Days: 5 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Sharpsburg, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob C. Grove

14. MOTHER'S MAIDEN NAME: Elizabeth Mumma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Lloyd S. Grove — Address: Norfolk, Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchial Pneumonia	7 days
450.0 — DUE TO (b)	Inanition	4 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c)	Arteriosclerosis - Gen.	4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from ..... 1956 to March 5, 1961, that (I) ~~(we)~~ last saw the deceased alive on March 5 1961, and that death occured at 6 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lloyd A. Hoffman M.D.

22b. DATE SIGNED: 4/5/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Lloyd A. Hoffman

22d. ADDRESS: 214 N. Pot. St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 7, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Albert K Leigh — **ADDRESS**: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 10 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4868 **CERTIFICATE OF DEATH** 04856

1 (M)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Hagerstown
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1843 Virginia Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Hagerstown
d. STREET ADDRESS: 1843 Virginia Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Gertrude — Last: Harsh

4. DATE OF DEATH: Month: April — Day: 2 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 25, 1880

9. AGE (In years last birthday): 80 yrs — IF UNDER 1 YEAR: Months: 4 Days: 7 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

I

13. FATHER'S NAME: Andrew Marr

14. MOTHER'S MAIDEN NAME: Emma Rose Wallick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Miss Emma C. Harsh — 1843 Virginia Ave. Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 — Arteriosclerotic Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/2/61 19.. to 4/2/61 19.., that (I) (we) last saw the deceased alive on 4/2/61 19.., and that death occured at 11:50PM, from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Young M.D. — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4/3/61

22c. PHYSICIAN'S NAME (Type): Ralph F. Young M.D. — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April 5, 1961 — 23c. NAME OF CEMETERY OR CREMATORY: Greenlawn Cemetery — 23d. LOCATION (City, town or county) (State): Williamsport, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Albert L. Leap — ADDRESS: Williamsport, Md.

25a. REC'D BY REGISTRAR DATE: APR 4 '61 — 25b. REGISTRAR'S SIGNATURE: C. Edna S. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4869 — 04857

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution, Residance before admission)
a. STATE: Pennsylvania — b. COUNTY: Franklin ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waynesboro
d. STREET ADDRESS: 24 N. Grant St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roy — Middle: C. — Last: Haugh

4. DATE OF DEATH: Month: April — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 4, 1883

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cornelius Haugh

14. MOTHER'S MAIDEN NAME: Mary Bierly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 173-03-1833

17. INFORMANT: Mrs. Mary K. Haugh, 24 N. Grant St., Penna. — Address: Waynesboro,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-Respiratory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 45 min
DUE TO (b): Diffuse metastatic Carcinoma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Prostatic Carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY ~~Month, Day~~, Year — Hour a.m. / p.m. — 19

20d. INJURY ~~OCCURRED~~ While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 12 1961, to April 14, 1961, that (I) (we) last saw the deceased alive on April 12 1961, and that death occured at 12:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M. E. Byrkit M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 4-14-61

22c. PHYSICIAN'S NAME (Type): M. E. Byrkit

22d. ADDRESS: Williamsport Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/18/1961

23c. NAME OF CEMETERY OR CREMATORY: Green Hill Cemetery

23d. LOCATION (City, town or county) (State): Waynesboro Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: B. Marlin Poe — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR — DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4870

04858

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 157 E. Antietam St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William; Middle: Oliver; Last: Heil

4. DATE OF DEATH: Month: April; Day: 9; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Unknown 1882

9. AGE (In years last birthday): About 79

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Drug Store

11. BIRTHPLACE (State or foreign country): Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Heil

14 MOTHER'S MAIDEN NAME: Carrie Irvin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-09-2660

17. INFORMANT: Clifton M. Bachtell — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b): Hypertensive Vasc. disease — 2 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

330X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p. m Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (~~this~~ hospital) attended the deceased from 1955, 19__, to April 9, 1961, that (I) (we) last saw the deceased alive on April 9 1961, and that death occurred at 4 P M, from the causes and on the date stated above

22a SIGNATURE: Lloyd A. Hoffman M.D.
ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4/10/61

22c. PHYSICIAN'S NAME (Type): Lloyd A. HOFFMAN

22d. ADDRESS: 214 N. Potomac St. Hagerstown, Md.

23a BURIAL, CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 4-12-61

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Scott F. Minnich & Son — ADDRESS: Hagerstown, Md.

25a. RECD BY REGISTRAR DATE: APR 12 61

25b REGISTRAR'S SIGNATURE: Emma L. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4871

CERTIFICATE OF DEATH

Reg. Dist. No. 04853

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MARTIN MANOR REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: TENN. A.
b. COUNTY: FRANKLIN
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - R. MERCERSBURG
d. STREET ADDRESS: R. #3 75 [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BEULAH Middle M. Last HILL

4. DATE OF DEATH: Month April Day 21 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/19/1897

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MERCERSBURG, PA, R.D.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL KISER

14. MOTHER'S MAIDEN NAME: ADA STRAITIFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: FRANK L. HILL, MERCERSBURG, PA, R.3
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): [illegible]
DUE TO (c):

174 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/30/61, 19____, to 4/21/61, 19____, that I last saw the deceased alive on 4-20 61, 19____, and that death occurred at 7:30 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 215 W Washington DATE SIGNED: 4/24/61

PHYSICIAN'S NAME (Type): DR E W HITE Hagerstown Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 4/24/61

22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEM.

22d. LOCATION (City, town, or county) (State): MERCERSBURG PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Thos. Eminger, ADDRESS: MERCERSBURG, PA.

24a. REC'D BY REGISTRAR DATE: APR 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,11,12,13 & 14 Information from birth certif. 4/28/61 iwk

4872

CERTIFICATE OF DEATH

Reg. Dist. No. 02860

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 47 Valley Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HUBERT Middle WAYNE Last HOFF

4. DATE OF DEATH: Month APR. Day 19 Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 19, 1961
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours 3 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oren Dale Hoff
14. MOTHER'S MAIDEN NAME: Laura Z. Frazee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immature Birth, — INTERVAL BETWEEN ONSET AND DEATH: 3 Minutes
DUE TO
(b) Atelectasis - Bilateral — Minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)
7625

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/19, 1961, to 4/19, 1961, that I last saw the deceased alive on 4/19, 1961, and that death occurred at 10:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Louis G. Graff M.D. ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type) LOUIS G. GRAFF, M.D. E. Antietam St.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 4/25/61
22c. NAME OF CEMETERY OR CREMATORY: Wash. Co. Hospital
22d. LOCATION (City, town, or county) (State): Hagerstown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Louis G. Graff M.D. ADDRESS
24a. REC'D BY REGISTRAR DATE APR 28 '61
24b. REGISTRAR'S SIGNATURE Clarence E. Stone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4873

CERTIFICATE OF DEATH

04861

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharpsburg
d. STREET ADDRESS: Sharpsburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: W — Last: Holmes

4. DATE OF DEATH: Month: April — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7 1875

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR, F UNDER 24 HRS.: Months: 11 — Days: 20 — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Henry Clay Holmes

14. MOTHER'S MAIDEN NAME: Margaret Bussard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mrs. Betsy Holmes Sharpsburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute uremia with oliguria. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO (b): Arterio-sclerotic CVR disease. — 5 Yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute cardiac decompensation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to 4/27/61, 19___, that (I) (we) last saw the deceased alive on 4/26/61 19__, and that death occurred at __ M, from the causes and on the date stated above.

22a. SIGNATURE: W. H. Shealy M D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 4/29/61

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 30-61

23c. NAME OF CEMETERY OR CREMATORY: Sampler Lanpr Cemetery

23d. LOCATION (City, town, or county) (State): Near Keedysville Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Albert L. Leaf Williamsport Md

25a. REC'D BY REGISTRAR — DATE: MAY 1 '61

25b. REGISTRAR'S SIGNATURE: Cuthbert S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
TSM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4874 Items 13,14 & 23b Film 6200 5/5/61 iwk 11486

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 414 Garlinger Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl Middle: Jenny Last: Kay

4. DATE OF DEATH: Month: April Day: 27, Year: 19 61

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 12, 1888
9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): waitress
10b. KIND OF BUSINESS OR INDUSTRY: restaurant
11. BIRTHPLACE (State or foreign country): Ringgold, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert H. Grazier
14. MOTHER'S MAIDEN NAME: Mary Ellen Northcraft

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 220-09-7658
17. INFORMANT: Charles B. Kay, Fayetteville, Pa. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
420.0
DUE TO (b): Mesenteric thrombosis — 2 days
DUE TO (c): Arteriosclerotic heart disease — 3 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Senile atherosclerosis
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1961 to 27 April 1961, that (I) (we) last saw the deceased alive on 27 April 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above

22a. SIGNATURE: Elden D Hoachlander M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4/28/61
22c. PHYSICIAN'S NAME (Type): Elden D Hoachlander
22d. ADDRESS: Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 1, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur J Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4875 — 30 — 04863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 138 Williams Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 138 Williams Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHERMAN — Middle FRANKLIN — Last KENDALL Sr
4. DATE OF DEATH: Month April — Day 26 — Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 15 1908
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith W. M. R. R. Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Smithsburg Wash Co Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JesseJ. Kendall
14. MOTHER'S MAIDEN NAME: Amanda Kline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO: 705-10-4634
17. INFORMANT — Address: Sherman F. Kendall Jr 666 Highland Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
Immediate cause (a): 5946-9 Acute Virus Infection Hagerstown Md — 4 Days
DUE TO (b): Acute Respiratory Infection — 4 Days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Alcoholism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY — Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED — While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 26 1961 to April 26 61 that (I) (we) last saw the deceased alive on April 26 61 and that death occurred at 8 PM from the causes and on the date stated above.

22a. SIGNATURE: H. B Beachley M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: April 28 61.
22c. PHYSICIAN'S NAME (Type): J. H. Beachley
22d. ADDRESS: Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/29/61
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR — DATE: MAY 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

VR A1S (4) 1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4876

CERTIFICATE OF DEATH

04864

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: WASHINGTON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 129 RAY STREET

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 129 RAY STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVER Middle: BERKLEY Last: KIBLER

4. DATE OF DEATH: Month: April Day: 14 Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 3 1897

9. AGE (If less than 1 day, last birthday): 63 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISHWASHER

10b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT

11. BIRTHPLACE (County & State, or foreign country): LURAY Virginia

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: CARL KIBLER

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO.: 214-09-7035

17. INFORMANT: FLORENCE A TYRE Address: 129 RAY ST. HAGERSTOWN Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uric Acid Pyelonephritis

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/14/61 19 to 4/14/61 19, that (I) (we) last saw the deceased alive on 4/14/61 19, and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph F Young MD

22b. DATE SIGNED: 4/14/61

22c. PHYSICIAN'S NAME (Type): RALPH F YOUNG MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: WILLIAMSPORT Md

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE THEREOF: 4/15/61

23c. NAME OF CEMETERY OR CREMATORY: ANATOMICAL Board of Md.

23d. LOCATION (City, town or county): BALTIMORE (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Sutter-Rouzer Funeral Home

ADDRESS: Hagerstown Md

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Cinthia S. Frame

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4877

CERTIFICATE OF DEATH

04865

1 M I

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Garlock Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 341 Elizabeth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: Frances — Last: Lightner

4. DATE OF DEATH: Month: April — Day: 28 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 7, 1886

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Williamsport, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hughes

14. MOTHER'S MAIDEN NAME: Mary Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. J. W. Lightner — Address: 341 Elizabeth Ave. Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Collapse
DUE TO (b): Arterio sclerosis Gen.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Min. / yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office b.dg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. ..... 19 56 to April 27 19 61, that (I) ~~(was)~~ last saw the deceased alive on April 27 19 61, and that death occured at ..... M. from the causes and on the date stated above.

22a. SIGNATURE: Louis G. Graff M.D. M.D.
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Louis G. Graff M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS: 119 E. Antietam St. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 1, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery
23d. LOCATION (City, town or county) (State): Hagerstown Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel
ADDRESS: Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 3 61
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

Wm. G. Hook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4378

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04866

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 24 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 44 S. CANNON AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
d. STREET ADDRESS: 44 S. CANNON AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle ARTHUR — Last MARINO

4. DATE OF DEATH: Month APRIL — Day 9 — Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/5/1910

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUTO MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: GARAGE

11. BIRTHPLACE (State or foreign country): ILLINOIS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 199-07-2010

17. INFORMANT: MRS. DOROTHY MARINO — Address HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Three days
DUE TO (b):
DUE TO (c):
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Edward W. Ditto III M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 4/12/61

EXAMINER'S NAME (Type): Edward W. Ditto III, M. D. Ac

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 4/11/61
22c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.
22d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: W. T. Norment — ADDRESS: Hagerstown, Md.
24a. REC'D BY REGISTRAR — DATE APR 12 '61
24b. REGISTRAR'S SIGNATURE: Anthony L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate omitting the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4879 — Item 2 Film G285 — 4/24/61 ivk — 04867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ~~Boonesboro~~ Smithsburg
d. STREET ADDRESS: ~~Keedys Nursing Home~~ RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Lewis — Middle C. — Last McClain
4. DATE OF DEATH: Month April — Day 11 — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 24, 1878
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Blue Ridge Summit Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elias McClain
14. MOTHER'S MAIDEN NAME: Mary M. Harbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 220-16-3414
17. INFORMANT — Address: Miss Jennette McClain Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 450.0 Generalized Lateriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO (b): Acute Haemorrhage of Bladder — 2 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from April 9 1961 to April 11 1961, that (I) (we) last saw the deceased alive on April 10 1961, and that death occurred at 5 A M, from the causes and on the date stated above

22a. SIGNATURE: G. W. LeVan M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4/12/61
22c. PHYSICIAN'S NAME (Type): G. W. LeVan
22d. ADDRESS: Boonsboro Md

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4-15-61
23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d. LOCATION (City, town, or county) (State): Smithsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Smithsburg, Md.
25a. REC'D BY REGISTRAR DATE: APR 17 61
25b. REGISTRAR'S SIGNATURE: Clinton L. Frame

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4880 302 04868

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1933 York Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a. STATE: W. Virginia
b. COUNTY: Morgan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berkeley Springs
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First LAWRENCE — Middle BAUMGARTNER — Last MICHAEL

4. DATE OF DEATH: Month April — Day 23 — Year 1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White		Nov 23 1896	64 yrs.		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Assessor of Morgan Co. W.Va.		Up W. Va Berkeley Springs Morgan	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James M. Michael	Mary Jane Householder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No		M. Michael Berkeley Springs, W.Va.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Arteriosclerotic Heart Desease
DUE TO (c): Malfunctioning Left Kidney

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 minutes / months / ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from April 12 1961, to April 23 1961, that (I) (we) last saw the deceased alive on April 20 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.

22a SIGNATURE: Philip J. Hirshman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4/24/61
22c PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.
22d ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City, town, or county) (State)
Burial	4/26/61	Sphors Cross Rd Cemetery	near Berkeley Springs Morgan Co. W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Andrew K. Coffman	Hagerstown Md.	APR 25 61	Chas. L. Mace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4887 (0486)

1 PLACE OF DEATH a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WESTERN MD. STATE HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MD. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTO.
d. STREET ADDRESS: 1008 W. PARRE ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Magdalena (LENA) Middle: Last: MICHEL

4. DATE OF DEATH: Month: 4 Day: 1 Year: 1961

5. SEX: F. 6. COLOR OR RACE: W. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 1, 1867
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10b. KIND OF BUSINESS OR INDUSTRY: O.H.
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES MAURER
14. MOTHER'S MAIDEN NAME: FREDERICKA — — —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: MR. HENRY MICHEL, 5550 LINK AVE #27.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lobular Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Gangrene with infection, left foot — 3 Months
DUE TO (c): Arteriosclerosis Obliterans Bilateral — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mard 23 1961 to April 1 1961 that (I) (we) last saw the deceased alive on April 1 1961, and that death occurred at 9.20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: April 1 1961
22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN
22d. ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 4/5/61
23c. NAME OF CEMETERY OR CREMATORY: LOUDON PK. CEMTY.
23d. LOCATION (City, town, or county) (State): BALTO, MD.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: WITZKE F.D. 410 EDMONDSON AVE.
25a. REC'D BY REGISTRAR DATE: APR 5 '61
25b. REGISTRAR'S SIGNATURE: C. H. S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 11/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4882

CERTIFICATE OF DEATH

04870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH — a. COUNTY: ~~Md.~~ Washington — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg
c. LENGTH OF STAY IN 1b: 60 Years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Smithsburg
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Smithsburg #2
d. STREET ADDRESS: Smithsburg #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E. Kinsey — Last: Miller
4. DATE OF DEATH: Month: April — Day: 3 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10/23/1879
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — IF UNDER 24 HRS: Days — Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Duties
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt. Lena, Washington Co., Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John T. Kinsey
14. MOTHER'S MAIDEN NAME: Sophia Ambrose
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: M. Harvey Miller Jr, Smithsburg Md., #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	7 days
DUE TO (b)	Cerebral arterio - Sclerosis	5 yrs
DUE TO (c)	Generalized arterio sclerosis	12 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from March 27, 1961, to April 3, 1961, that (I) ~~(we)~~ last saw the deceased alive on April 3 1961, and that death occurred at 6 P. M, from the causes and on the date stated above.

22a. SIGNATURE: Wallie H Wishard M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 4-4-61
22c. PHYSICIAN'S NAME (Type): Walter H Wishard
22d. ADDRESS: 152 Downing Waynesboro - Penna

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/6/61
23c. NAME OF CEMETERY OR CREMATORY: Welty's Cemetery
23d. LOCATION (City, town, or county) (State): Smithsburg #2, Washington Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible] Home, Waynesboro Pa
25a. REC'D BY REGISTRAR DATE: APR 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4883 04871

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Downsville
c. LENGTH OF STAY IN 1b: 1½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Woburn Home

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 68½ E. Franklin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maxwell; Middle Matthew; Last Monn

4. DATE OF DEATH: Month April; Day 29; Year 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 12, 1908
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): messenber
10b. KIND OF BUSINESS OR INDUSTRY: bank
11. BIRTHPLACE (State or foreign country): Mt. Alto, Penna.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Matthew S. Monn
14. MOTHER'S MAIDEN NAME: Nellie Shockey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: 174-01-3993
17. INFORMANT: Mrs. Thelma S. Monn — Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cor-Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Mos.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a m. p m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/26/61 19___ to 4/29/61 19___ that (I) (we) last saw the deceased alive on 4/29/61 19___ and that death occurred at 11:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ralph Young — M D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Ralph Young
22d. ADDRESS: Williamsport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: May 2, 1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Cem.
23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE: MAY 1 '61
25b. REGISTRAR'S SIGNATURE: Evelyn S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4884 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04872

1. **PLACE OF DEATH**
   a. COUNTY: Washington
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   c. LENGTH OF STAY IN 1b: 3 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash County Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 382 Blooms Alley
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First GEORGE; Middle C; Last LONROE

4. **DATE OF DEATH**: April 7 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jany 3 1932

9. AGE (In years last birthday): 29 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labored

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Millwood Clark Co Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Lonroe

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) --

16. SOCIAL SECURITY NO. --

17. INFORMANT: William C. Elliott Washington D.C.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Esophagomalacia with Rupture Into Left Pleural Cavity.	Several Hours
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Fracture Simple, Occipital bone Left.	4 days
DUE TO (c)	Cerebral Contusion & Laceration Intracerebral Hemorrhage.	4days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Fell striking head (Possibly Intoxicated.)

20c. TIME OF INJURY Hour a.m. 10:50 Month, Day, Year 4-3- 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public Alley

20f. (City or town): Hagerstown (County): Washington (State): Md.

21 I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: J. M. Outt M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. W. . Di[illegible]s, Jr.

Address (Street, city, town, or county):

DATE SIGNED: 4-[illegible]-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/13/61

22c. NAME OF CEMETERY OR CREMATORY: Little Chapel Cemetery

22d. LOCATION (City, town, or country): Millwood Clark Co Va.

23. FUNERAL DIRECTOR: Andrew K. Coffman

ADDRESS: Hagerstown Md

24a. REC'D BY REGISTRAR DATE: APR 12 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4885 04873

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Williamsport Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Ross St. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna Middle: Elizabeth Last: Mowen

4. DATE OF DEATH: Month: 4 Day: 3 Year: 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 23, 1871

9. AGE (In years last birthday): 89 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Shank

14. MOTHER'S MAIDEN NAME: Catherine Hurtman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Nannye Loudenslager Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.0 Coronary Thrombosis Heart Fail
DUE TO (b): Senility
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 3-1- 19 61, to 4-3 19 61, that (I) (we) last saw the deceased alive on 3-24 1961, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: L. W. Leitz M. D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): LEWIS LEITZ

22d. ADDRESS: Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4-5-61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 6 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4886

CERTIFICATE OF DEATH

04874

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Smithsburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: #2

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Smithsburg
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Raymond — Middle Henry — Last Myers

4. DATE OF DEATH: Month April — Day 19, — Year 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: June 1, 1887

9. AGE (In years last birthday): 73 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: truck farm

11. BIRTHPLACE (State or foreign country): Ringgold, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William D. Myers

14. MOTHER'S MAIDEN NAME: Alice Reynolds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 215-36-7068

17. INFORMANT: Mrs. Helena A. Myers, Smithsbur, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO (b): Arteriosclerotic Cardiovascular Disease — 5 Yrs.
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/22, 1954, to 4/12, 1961, that (I) (we) last saw the deceased alive on 4/7, 1961, and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M D

ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED: 4/20/61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess M.D.

22d. ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 4-22-61

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery

23d. LOCATION (City, town, or county) (State): Smithsburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Smithsburg, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Charles F. Hess

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4887 04875

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 PLACE OF DEATH — a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Frederick

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown — c. LENGTH OF STAY IN 1b: 31 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Emmitsburg, — ICX-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland Hospital — d. STREET ADDRESS: 320 West Main — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Alice — Last: OHLER

4. DATE OF DEATH: Month: 4 — Day: 4 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1864

9. AGE (In years last birthday): 96 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frederick Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry M. Eiler

14. MOTHER'S MAIDEN NAME: Mary Fogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Blanche Wilhide, Address: 528 North Beaver Street, York, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Lobular Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 17 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (b): Gastric bleeding — 9 days

5400 — DUE TO (c): Gastric Ulcer — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from March 3, 1961, to April 4, 1961, that (I) (~~was~~) last saw the deceased alive on April 4, 1961, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

22a SIGNATURE: Young E. Chun M.D — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ — 22b DATE SIGNED: April 4. 1961

22c PHYSICIAN'S NAME (Type): YOUNG E. CHUN — 22d ADDRESS: 1500 Penna. Ave. Hagerstown, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April, 6, 1961 — 23c NAME OF CEMETERY OR CREMATORY: Keysville Cemetery — 23d LOCATION (City, town, or county) (State): Carroll County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C. E. Wilson — ADDRESS: Emmitsburg, Md.

25a REC'D BY REGISTRAR DATE: APR 7 '61 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Kinna

C. E. Wilson

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0487a

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 30 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 316 W. Washington St.

d. STREET ADDRESS: 316 W. Washington St.

IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith Middle: Marietta Last: Orcutt

4. DATE OF DEATH: Month: Apr. Day: 8 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 18, 1878

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Locust Grove, Wash. Cty. U.S.A. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Smith

14. MOTHER'S MAIDEN NAME: Anna Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mrs. Bertha Bentz, 323 W. Howard St. Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

DUE TO

3 or X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive Vascular Disease — 10 years

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 10, 1961 to April 8, 1961, that (I) (we) last saw the deceased alive on April 5, 1961, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-10-61

22c. PHYSICIAN'S NAME (Type): Dr. E. M. Ditto, Jr.

22d. ADDRESS: 215 E. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md. Wash. Co.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

95 Years 4889 — 95 years 04871

M

1. PLACE OF DEATH
a. COUNTY Hancock Wash Co — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE W. Va. b. COUNTY Harrison ✓

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Clarksburg, W. Va.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Hancock Rest Home Wash Co Hancock Md

d. STREET ADDRESS
Waldo Hotel

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Minnie Middle: Byrne Last: Pickens

4. DATE OF DEATH Month: 4 Day: 17 Year: 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 4 7 1866

9. AGE (In years last birthday) 95 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Barbour Co W Va

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Marshall Coburn

14. MOTHER'S MAIDEN NAME: Columbia Arnold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: E M Bearinger Address: Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO (b) Arteriosclerotic Heart Disease — 20 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Generalized Arteriosclerosis — 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) No injury

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-6 1961, to 4-13 1961, that (I) (we) last saw the deceased alive on 4-13 1961, and that death occurred at 3:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE Frank B Thomas III M. D. M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) FRANK B. THOMAS III M.D.

22d. ADDRESS HANCOCK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/17/61

23c. NAME OF CEMETERY OR CREMATORY: Elkview Masonic

23d. LOCATION (City, town, or county) (State): Clarksburg W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: H. L. Weaver

ADDRESS: Clarksburg

25a. REC'D BY REGISTRAR DATE APR 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4890 04878

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: W.Md State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CB Hagerstown
d. STREET ADDRESS: 813 Virginia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA — Middle: Dubel — Last: PRATT
4. DATE OF DEATH: Month: APRIL — Day: 17 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 12 1875
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: IOwn Home
11. BIRTHPLACE (State or foreign country): Wolfesville Fred Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Dubel
14. MOTHER'S MAIDEN NAME: Charlotte Renner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Alvey Rubel 108 Coffman Ave Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INFARCTION OF LARGE SMALL INTESTINE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO (b): THROMBOTIC OCCLUSION OF SUPERIOR MESETERIC — 2 DAYS
DUE TO (c): GENERALIZED ATHEROSCLEROSIS — NOT KNOWN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this physician~~) attended the deceased from 4-14- 1961 to 4-17 - 1961, that (I) (~~we~~) last saw the deceased alive on 4-17 1961, and that death occurred at 11:25 M, from the causes and on the date stated above

22a. SIGNATURE: Antonio U. Pallagrosi M.D — ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 4/17/61
22c. PHYSICIAN'S NAME (Type): ANTONIO U. PALLAGROSI
22d. ADDRESS: 1500 PENNA AVE HAGERSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/19/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Andrew K. Coffman Hagerstown Md.
25a. REC'D BY REGISTRAR DATE: APR 20 '61
25b. REGISTRAR'S SIGNATURE: Clarence L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

489 1 (1487)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Co. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 408 No Prospect St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELMER — Middle ELLSWORTH — Last RAILING

4. DATE OF DEATH: Month April — Day 19 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 37 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter Hag Shoe Co

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md Middlesex Cunberland Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Railing

14. MOTHER'S MAIDEN NAME: Katie Ashenfelter

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 214-09-5613

17. INFORMANT: Mrs Olive J. Railing — Address: 408 No Prospect St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Hagerstown Md.

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — 7 days
DUE TO
(b): Cerebral Arterio Sclerotic Heart Disease — 10 yrs
DUE TO
(c): Cerebral Cirrhosis — 5 mo

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-12-61 19 to 4-19 19 61, that (I) (we) last saw the deceased alive on 4-18-61 19, and that death occurred at 7:00 A.M. from the causes and on the date stated above

22a. SIGNATURE: J. W. Duty M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. W. Duty

22d. ADDRESS: Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/21/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem. Gardens

23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman — ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4892 — 04880

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hagerstown, Rural
c. LENGTH OF STAY IN 1b: 29 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.F.D. # 3

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d. STREET ADDRESS: R.F.D. #3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF (Type or print): First: GAY — Middle: CATHERINE — Last: REEL

4. DATE OF DEATH: Month: April — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: March 7, 1892

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country): Sharpsburg, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas H. Reel

14. MOTHER'S MAIDEN NAME: Mary C. Grice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Miss. Daisy M. Reel Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Months

DUE TO (b): 420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Post ..... 19..... that (I) (we) last saw the deceased alive on 4/10 ..... 1961., and that death occured at 5:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D. — ATTENDING PHYS. [X] MED. EXAMINER [ ] CORONER [ ]

22b. DATE SIGNED: 4/13/61

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M.D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/15/1961

23c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4893

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH — a. COUNTY: Washington — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 21 Days

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE: Md. — b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Smithsburg

d. STREET ADDRESS: J Smithsburg #2

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elder — Middle: Blaine — Last: Reynolds

4. DATE OF DEATH: Month: April — Day: 6, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/20/1886

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Planning Mill

11. BIRTHPLACE (State or foreign country): Ringgold, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Reynolds

14. MOTHER'S MAIDEN NAME: Nancy Shockey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 220-30-7503A.

17. INFORMANT Address: Mrs. Eva Reynolds, Smithsburg Md., #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Cerebral Thrombosis	3 Wks.
DUE TO (b)	Generalized Arteriosclerosis	5 Yrs.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-10, 1961, to 4-6, 1961, that (I) (we) last saw the deceased alive on 4-5 1961, and that death occurred at 3:10 AM, from the causes and on the date stated above.

22a. SIGNATURE: Charles F. Hess M.D

ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-6-61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess

22d. ADDRESS: Smithsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/61

23c. NAME OF CEMETERY OR CREMATORY: Smithsburg

23d. LOCATION (City, town, or county) (State): Smithsburg, Washington Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Walter J. Hess — **ADDRESS**: Waynesboro, Pa

25a. REC'D BY REGISTRAR DATE APR 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kreiss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4894 04882

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 5 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. Co. Hospital
d. STREET ADDRESS: 101 Fairground Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hubert Middle: Walter Last: Routzahn
4. DATE OF DEATH: Month: 4 Day: 2 Year: 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Nov. 12, 1899
9. AGE (In years last birthday): 61 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): taxi driver
10b. KIND OF BUSINESS OR INDUSTRY: taxi
11. BIRTHPLACE (State or foreign country): Frederick Co. Md.
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hubert W. Routzahn Sr.
14. MOTHER'S MAIDEN NAME: Mary Alice Firestone

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 214-09-7159
17 INFORMANT: Mrs. Hazel Snively Address: Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Carcinoma of the esophagus with metastasis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

150X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 19 19 60 to April 2 19 61 that (I) (we) last saw the deceased alive on April 2 19 61 and that death occurred at 11:27 P M, from the causes and on the date stated above

22a SIGNATURE: B. B. Kneisley M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b DATE SIGNED: 4/3/61

22c PHYSICIAN'S NAME (Type): B. B. Kneisley, M.D.
22d. ADDRESS: 148 West Washington St., Hagerstown Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 4-5-61
23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d LOCATION (City, town or county) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Fred W. Kraiss Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE APR 6 '61
25b. REGISTRAR'S SIGNATURE: Esther S. Hess

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4895

CERTIFICATE OF DEATH

04863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, **TO FUNERAL DIRECTOR:** page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 PLACE OF DEATH — a. COUNTY: WASHINGTON — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN — c. LENGTH OF STAY IN 1b: 60 YRS.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARLOCK MEM. CONV. HOSPITAL

d. STREET ADDRESS: 950 SUMMIT AVE.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CATHERINE — Middle: MALAVERY — Last: SAUM

4. DATE OF DEATH: Month: APRIL — Day: 4 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/13/1880

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: SAMUEL E. CONRAD

14. MOTHER'S MAIDEN NAME: FLORENCE ROBINSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: MISS ELIZABETH SAUM HAGERSTOWN MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Senile Dementia — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis — 5 yrs +

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Jan 1950 to Apr 4 1961, that (I) (we) last saw the deceased alive on 3 Apr 1961 and that death occurred at 5 A.M., from the causes and on the date stated above.

22a. SIGNATURE: F F Lusby — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): F F Lusby — 22d. ADDRESS: 230 N Potomac St — 5 Apr 61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 4/6/61 — 23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM. — 23d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. T. Norment, Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 7 '61 — 25b. REGISTRAR'S SIGNATURE: Clarence E. Frantz

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4896

CERTIFICATE OF DEATH

04864

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 19 Yrs
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 37 East Antietam St

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): C3 Hagerstown
d. STREET ADDRESS: 37 East Antietam St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VIOLET — Middle SAVANNA — Last SCHILDTKNECHT

4. DATE OF DEATH: Month April — Day 20 — Year 1961

5 SEX: Female
6 COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 20 1895
9 AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months — Days — Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balls Station Wash Co Md
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles C. South
14. MOTHER'S MAIDEN NAME: Lydia Gaylor

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16 SOCIAL SECURITY NO.: None
17 INFORMANT: Allen Schildtknecht — Address: 39 E. Antietam St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — Hagerstown Md. — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO (b): Hypertensive C-V Disease — 2-3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X
DUE TO (c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Jan 1945 to 20 Apr 1961, that (I) (~~was~~) last saw the deceased alive on 12 Apr 1961, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22a SIGNATURE: F F Lusby M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 21 Apr 61
22c. PHYSICIAN'S NAME (Type): F F Lusby
22d. ADDRESS: 230 W Potomac

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4/23/61
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d LOCATION (City, town, or county) (State): Hagerstown Wash Co Md

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Andrew K. Coffman Hagerstown Md
25a REC'D BY REGISTRAR: DATE APR 24 '61
25b. REGISTRAR'S SIGNATURE: Clothus L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, omitting the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4897 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04865

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN this MARYLAND: 7 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hagerstown Golf Club

2. USUAL RESIDENCE (Where deceased lived, If institution: Resident before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 03 Hagerstown
d. STREET ADDRESS: 515 Dual Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: Clarence; Last: Seacrist

4. DATE OF DEATH: Month: April; Day: 12; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1917

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Greenskeeper

10b. KIND OF BUSINESS OR INDUSTRY: Golf Club

11. BIRTHPLACE (State or foreign country): Crown Hill W. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alanzo Seacrist

14. MOTHER'S MAIDEN NAME: Stella Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 233-07-3238

17. INFORMANT: Mrs. Dorothy M. Seacrist Address: Hagerstown, M

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushing Injury Of Chest Fractures Of Ribs 2-2, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: Instant

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Laceration Of Heart & Pericardium
DUE TO: Hemothorax
(c): Laceration Of Liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.): While bulldozing struck by swinging tree.

20c. TIME OF INJURY: Hour a.m. 10:2; Month, Day, Year: 4-12-1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): City Golf Course

20f. (City or town): Hagerstown, Washington (County): (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. [illegible] Ditto, Jr.

Address (Street, city, town, or county):

DATE SIGNED: 4-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-16-61

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country): Hagerstown, (State): Md.

23. FUNERAL DIRECTOR: Scott F. Minnich & Son ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR DATE: APR 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kline

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4893

CERTIFICATE OF DEATH

04883

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
c. LENGTH OF STAY IN 1b: 32 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Hagerstown #5

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown
d STREET ADDRESS: Hagerstown #5
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtie — Middle: Ann — Last: Shifflett

4. DATE OF DEATH: Month: April — Day: 8 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 20, 1886

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles David

14. MOTHER'S MAIDEN NAME: Jane Herring

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17 INFORMANT: Mrs. W. C. Minnick, Sr. — Address: Quincy, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Generalized ... toxic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr.

DUE TO (b): Probably fro... kidney — 2 Mo.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Arteriosclerotic Cardiovascular disease — 10 Yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-11-____, 19 60 to A.M. 4-8-61, 1961, that (I) (we) last saw the deceased alive on 4-6-61 19___, and that death occurred at 12 M, from the causes and on the date stated above

22a SIGNATURE: Charles F. Hess M D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-3-61

22c. PHYSICIAN'S NAME (Type): Charles F. Hess, M. D.

22d. ADDRESS: Hagerstown, Maryland

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 4/11/61

23c NAME OF CEMETERY OR CREMATORY: Ringgold

23d LOCATION (City, town, or county) (State): Smithsburg #2, Washington, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Walter Y. Grove — ADDRESS: Waynesboro, Penna.

25a. REC'D BY REGISTRAR DATE APR 12 '61

25b. REGISTRAR'S SIGNATURE: C. Wm. Rowe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ... director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
15M 9/59

Item 20 Film 284 4-12-61 Pic

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04884

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Washington
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock
   c. LENGTH OF STAY IN 1b: MARYLAND Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hancock, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hancock, Md.
   d. STREET ADDRESS: Hancock
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbur Middle: James Last: Shives

4. DATE OF DEATH: Month: 4 Day: 4 Year: 19 61

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/14/1900

9. AGE (In years last birthday): 61 yrs
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Hauling

10b. KIND OF BUSINESS OR INDUSTRY: Truck Hauling

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pete S. Shives

14. MOTHER'S MAIDEN NAME: Harriet A. Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-18-9551

17. INFORMANT: Chester Shives, Address: High St. Hancock, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fracture Of Cervical Vertebra — INTERVAL BETWEEN ONSET AND DEATH: Instant
178X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Patient jumped from top of bridge (40 feet)

20c. TIME OF INJURY Hour: 8:50 p.m. XXX Month, Day, Year: 4-4-61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Public highway

20f. (City or town): Hancock (County): Wash. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: A. W. Dutton M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. E. J. Dilts, Jr.

Address (Street, city, town, or county):

DATE SIGNED: 4-5-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/8/61

22c. NAME OF CEMETERY OR CREMATORY: Piney Plains Methodist

22d. LOCATION (City, town, or country): Allegany Co. (State): Maryland

23. FUNERAL DIRECTOR: Howard F. Stone ADDRESS: Hancock, Md.

24a. REC'D BY REGISTRAR DATE: APR 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4900

CERTIFICATE OF DEATH

04883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Homewood Church Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Williamsport Pike
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: M.; Last: Smith

4. DATE OF DEATH: Month: Apr.; Day: 8; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1879

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Seersville, Northampton Cty., Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Israel Remaley

14. MOTHER'S MAIDEN NAME: Matilda Donner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17 INFORMANT: Mrs. Mark Wagner, Homewood Church Home, Williamsport Pike, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular Collapse
DUE TO (b): Cerebral Thrombosis
DUE TO (c): Hypertension Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Ann. day hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psycho-manic - depressive

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY: Hour; a.m. p.m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from [illegible] 1961, to 4/8, 1961, that (I) (we) last saw the deceased alive on 4/7, 1961, and that death occurred at [illegible] M. from the causes and on the date stated above.

22a SIGNATURE: Louis G. Huff M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 4/8/61

22c PHYSICIAN'S NAME (Type): Louis G. Huff

22d ADDRESS: [illegible] Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/12/61

23c NAME OF CEMETERY OR CREMATORY: St. Peter's Church Cem. Seersville, Pa.

23d LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 12 '61

25b REGISTRAR'S SIGNATURE: Clifton L. Firaus

VR A1S (4)
15M 9/59

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4901 1148

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Williamsport
d STREET ADDRESS: 17 Frederick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Rosie Middle Belle Last SMITH

4. DATE OF DEATH: Month 4 Day 24 Year 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 15 1879

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months 0 Days 8
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Homes

11 BIRTHPLACE (State or foreign country): Williamsport Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Nelson Smith

14. MOTHER'S MAIDEN NAME: Rosie (Unknown)

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Family Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobular Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: One Week
DUE TO (b) Diabetes Mellitus — 7 years
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease, Infection of legs

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a. m p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 29 1961 to April 24 1961 that (I) (~~was~~) last saw the deceased alive on April 24 1961, and that death occurred at 11:45 P. M. from the causes and on the date stated above

22a. SIGNATURE: Young E. Chun M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: April 25 1961

22c PHYSICIAN'S NAME (Type): YOUNG E. CHUN

22d ADDRESS: 1500 Penna Ave Hagerstown, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: April 28-61

23c NAME OF CEMETERY OR CREMATORY: Riverview Cemetery

23d LOCATION (City, town, or County) (State): Williamsport Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert L. Kopf Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 27 '61

25b REGISTRAR'S SIGNATURE: Cynthia L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4907 — 04890

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 1
c. LENGTH OF STAY IN 1b: 18 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: near Cavetown

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Smithsburg R # 1
d. STREET ADDRESS: near Cavetown
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ARTHUR Middle LEE Last SPRECHER

4. DATE OF DEATH: Month April Day 25 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March 33 1885

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Williamsport Wash co Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Sprecher

14. MOTHER'S MAIDEN NAME: Missouri Stahl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: 216-22-8216

17. INFORMANT: Mrs Louise Pittenger
Address: R # 1 Smithsburg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coarctation of Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 25 mts
332X
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Arterio Sclerosis Generalized — 7 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1 19 60 to April 25 19 61 that (I) (we) last saw the deceased alive on April 25 19 61 and that death occurred at 8 AM, from the causes and on the date stated above

22a. SIGNATURE: G. A. Kohler M.D
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED: April 27 1961

22c. PHYSICIAN'S NAME (Type): G. A. KOHLER

22d ADDRESS: Smithsburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/28/61
23c NAME OF CEMETERY OR CREMATORY: Smithsburg Cemetery
23d LOCATION (City, town, or county) (State): Smithsburg Wash Co Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md

25a. REC'D BY REGISTRAR DATE: MAY 2 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4303

CERTIFICATE OF DEATH

303 0489

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 53 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 938 Spruce St

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 938 Spruce St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID Middle CLYDE Last STOUFFER
4. DATE OF DEATH: Month April Day 11 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 12 1882
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tin Smith
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Cavetown Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William H. Stouffer
14. MOTHER'S MAIDEN NAME: Lillie Sigler
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Vera G. Stouffer Address: 938 Spruce St Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Glomer. Nephritis
DUE TO (b): Arteri-sclerotic Heart Disease
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: April 1-61

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from March 18 1961 to April 11 1961, that (I) (we) last saw the deceased alive on April 11 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a SIGNATURE: Sidney Noverstein M.D
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 4-11-61
22c PHYSICIAN'S NAME (Type): SIDNEY NOVERSTEIN
22d. ADDRESS: FUNKSTOWN MD

23a BUR AL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 4/13/61
23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.
25a REC'D BY REGISTRAR DATE: APR 14 '61
25b REGISTRAR'S SIGNATURE: Cullen L Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4904 Reg. Dist. No. 04892

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Hagerstown
c. LENGTH OF STAY IN 1b –
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 81

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE West Virginia b. COUNTY Hardy
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milgap
d. STREET ADDRESS R 5 x-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First JENNINGS Middle LEE Last STRAWDERMAN
4. DATE OF DEATH Month Apr. Day 16 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Apr. 5, 1927
9. AGE (In years last birthday) 34 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mathias, Hardy Co., W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Albert S. Strawderman
14. MOTHER'S MAIDEN NAME Mamie Mathias

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT Address Dellinger Funeral Home, Woodstock, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 810X ~~Compound fractures~~ of skull with one quarter of skull and face torn away. Multiple comminuted
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) fractures of right leg and left leg.

INTERVAL BETWEEN ONSET AND DEATH: Instant

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Tractor missed overhead bridge landing on railroad then hit by oncoming train.
20c. TIME OF INJURY Hour 4:00 a.m. p.m. Month, Day, Year 4-16-61 19
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fed. Route #81
20f. (City or town) Hagerstown (County) Washington (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE E. W. Ditto M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type) Dr. E.W. Ditto, Jr.
DATE SIGNED 4/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4/18/61
22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemtery
22d. LOCATION (City, town, or county) Lost River, Hardy Co., W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman, Hagerstown, Md.
24a. REC'D BY REGISTRAR DATE APR 18 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4905

CERTIFICATE OF DEATH

04893

1 PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Western Maryland State Hospital

2. USUAL RESIDENCE (Where deceased lived — If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 325 N. Locust St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: James — Last: STRAWSBURG

4. DATE OF DEATH: Month: 4 — Day: 27 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 1, 1890

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): general work

10b. KIND OF BUSINESS OR INDUSTRY: awning mfg.

11. BIRTHPLACE (State or foreign country): Carroll County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph J. Strawsburg

14. MOTHER'S MAIDEN NAME: Mary Whitelether

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-09-0371

17. INFORMANT: Mrs. George Pappas, Hagerstown, Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from March 20 1961 to April 27, 1961, that (I) (~~me~~) last saw the deceased alive on April 27, 1961, and that death occurred at 1:05 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Young E. Chun M.D.
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: April 29, 1961

22c. PHYSICIAN'S NAME (Type): YOUNG E. CHUN

22d. ADDRESS: 1500 penna. Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: Apr. 30, 61

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Scott F. Minnich & Son, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '61

25b. REGISTRAR'S SIGNATURE: Clarence L. Kann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4906 — 04894

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 617 N. Prospect St.,

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Wash.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 617 N. Prospect
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Lester	W	Strosnider	4	25	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white		March 11, 1908	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Yard Man	Jamison Cold Storage	Strausburg, Va.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	228-30-5492	Mrs. Alice K. Strosnider	Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Recent
DUE TO (b): Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE: Fred W. Kraiss M.D.
EXAMINER'S NAME (Type): FRED W. KRAISS
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 4/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country)	(State)
burial	4-28-61	Rose Hill Cemetery	Hagerstown	Md.

23. FUNERAL DIRECTOR	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Fred W. Kraiss	Hagerstown, Md.	APR 28 '61	Arthur L. Kraiss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4907 0489

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 31 Frederick Road

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Funkstown
d. STREET ADDRESS: 31 Frederick Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lora — Middle: Agnes — Last: Sweeney

4. DATE OF DEATH: Month: April — Day: 9 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 16 1894

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months: 5 Days: 23 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Restaurant

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (County & State, or foreign country): Antietam Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: George W. Otzelberger

14. MOTHER'S MAIDEN NAME: Catherine Gift

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): 219-20-1219

17. INFORMANT: Mr. Victor H. Sweeney — Address: 31 Frederick Road Funkstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): coronary ateriosclerosis. — 1 year

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1, 1961, to Apr. 9, 1961, that (I) (we) last saw the deceased alive on 4/7/61 19..., and that death occured at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Walter H. Shealy M.D.

22b. DATE SIGNED: 4/11/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Walter H. Shealy M. D.

22d. ADDRESS: Sharpsburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 12-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

23d. LOCATION (City, town or county) (State): Sharpsburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Albert L Leaf

ADDRESS: Williamsport, Md

25a. REC'D BY REGISTRAR DATE: APR 13 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4903 — 04895

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b: 48 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASHINGTON COUNTY HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 HAGERSTOWN
d. STREET ADDRESS: 238 FREDERICK ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle LEOTA — Last TROVINGER

4. DATE OF DEATH: Month APRIL — Day 20 — Year 19 61

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/13/1904

9. AGE (In years last birthday): 57 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ELIJAH BAKER

14. MOTHER'S MAIDEN NAME: FANNIE EYLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-30-6168

17. INFORMANT: MR. RAYMOND T. TROVINGER — Address: HAGERSTOWN MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cachexia	1 week
DUE TO		
(b)	Carcinomatosis	5 months
DUE TO		
(c)	Carcinoma of ovary	5 months

1715.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18-61, 19__, to 4-20-61, 19__, that (I) (we) last saw the deceased alive on 4-20-61 19__, and that death occurred at 9:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul Harrison M.D

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4-22-61

22c. PHYSICIAN'S NAME (Type): Paul Harrison, M. D.

22d. ADDRESS: 318 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4/23/61

23c. NAME OF CEMETERY OR CREMATORY: ROSE HILL CEM.

23d. LOCATION (City, town, or county) (State): HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. J. Kornrumpf, Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4909 — 048[illegible]

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 661 Forrest Drive
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MERLE — Middle: RICHARD — Last: VAUGHN III

4. DATE OF DEATH: Month: April — Day: 13 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 13, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days: 1 — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Hagerstown, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Merle Vaughn

14. MOTHER'S MAIDEN NAME: Jeanette Polley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Merle Vaughn — Address: Hagerstown, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): Atelectasis — Premature Birth 7 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 13, 1961 to ..April 13 1961, that (I) (we) last saw the deceased alive on April 13 1961, and that death occured at 3:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Philip J. Hirshman M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4/14/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/14/1961

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county): Hagerstown (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Suter - Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4910

CERTIFICATE OF DEATH

04898

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash County Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 437 West Antietam St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LUTHER Middle MAC Last WALLECH

4. DATE OF DEATH: Month April Day 9 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 1 1908

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator

10b. KIND OF BUSINESS OR INDUSTRY: County Roads Dept

11. BIRTHPLACE (State or foreign country): Greencastle Franklin Co Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Wallech

14. MOTHER'S MAIDEN NAME: Susie Cordell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 195-16-3941

17. INFORMANT: Address: Mrs Florence S. Wallech 437 W. Antietam Hagerstown Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b): Multiple coronary artery occlusion — 11 weeks
DUE TO (c): Coronary atherosclerosis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic bronchitis and emphysema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1959 to Apr 7 1961, that (I) (we) last saw the deceased alive on Apr 8 1961, and that death occurred at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John C. Stauffer M.D
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John C. Stauffer
145 So Prospect St

22d. ADDRESS: Hagerstown Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 4/12/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Mem Gardens
23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Andrew K. Coffman
ADDRESS: Hagerstown Md.

25a. REC'D BY REGISTRAR: DATE APR 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4911

CERTIFICATE OF DEATH

0489

1. PLACE OF DEATH
a. COUNTY: Washington — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Home Rural Hancock

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hancock
d. STREET ADDRESS: Rural Hancock
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olive — Middle: May — Last: Weller

4. DATE OF DEATH: Month: 4 — Day: 16 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/21/05

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Fulton Co., Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Mellott

14. MOTHER'S MAIDEN NAME: Margaret Keefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Howard J. Weller Rural 2 Hancock, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (b): Diabetes

DUE TO (c): Arteriosclerosis

26 UX

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 16 19 61 to Apr 16 19 61, that (I) (we) last saw the deceased alive on Apr 16 19 61 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: L M Shaffer — M. D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L. M. SHAFFER

22d. ADDRESS: HANCOCK Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/18/61

23c. NAME OF CEMETERY OR CREMATORY: Orchard Ridge

23d. LOCATION (City, town, or county) (State): Washington Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Howard J. Heine — ADDRESS: Hancock md

25a. REC'D BY REGISTRAR — DATE: APR 18 '61

25b. REGISTRAR'S SIGNATURE: Clothus L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4912

CERTIFICATE OF DEATH

049:0

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Md.

c. LENGTH OF STAY IN 1b: 25yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown, Maryland.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 331 N. Jonathan Street

d. STREET ADDRESS: 331 N. Jonathan Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bryant Middle: (no) Last: William

4. DATE OF DEATH: Month: April Day: 23 Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7-12-1906

9. AGE (In years last birthday): 54 yrs

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Letterkenny depot

11. BIRTHPLACE (State or foreign country): Marion, S.C.

12 CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: John William

14. MOTHER'S MAIDEN NAME: Augusta Hamies

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hazel Adams Address: 116 W. Bethel Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma - Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO (b):

DUE TO (c):

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19 WAS ALTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/22 1960 to April 23 1961, that (I) (we) last saw the deceased alive on April 23 1961, and that death occurred at 5P M, from the causes and on the date stated above.

22a SIGNATURE: Philip J. Hirshman M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 4/26/61

22c. PHYSICIAN'S NAME (Type): Philip J. Hirshman, M.D.

22d. ADDRESS: 159 W. Washington St. Hagerstown, Maryland

23a BURIAL CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: May 1 1961

23c NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d LOCATION (City, town, or county) (State): Hagerstown Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John R Watson ADDRESS: Hagerstown Md

25a REC'D BY REGISTRAR DATE: MAY 2. '61

25b. REGISTRAR'S SIGNATURE: Luther S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

(M)

(I)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4913

CERTIFICATE OF DEATH

049-61

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hagerstown R#5
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hagerstown R#5

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
e. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hagerstown R#5
d. STREET ADDRESS: 1 Hagerstown R#5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: Elizabeth — Last: Williams

4. DATE OF DEATH: Month: April — Day: 18 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Dec. 7, 1881

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Washington Co. Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Hartman

14. MOTHER'S MAIDEN NAME: Sarah Warfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: J.E. Williams Hagerstown, Md. R#5

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Arteri-sclerosis
DUE TO (c): Arteri-sclerotic Heart D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Dec, 1961

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 15, 19 61 to April 18, 19 61, that (I) (we) last saw the deceased alive on April 18, 19 61, and that death occured at 5 P.M. from the causes and on the date stated above.

22a SIGNATURE: Sidney Rovenstein M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 4-19-61

22c. PHYSICIAN'S NAME (Type): SIDNEY ROVENSTEIN

22d ADDRESS: FUNKSTOWN MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/21/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county): Hagerstown (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: APR 20 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

Wm. G. Horak

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4914 — 049 62

1. **PLACE OF DEATH**
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 118 Alexander St.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 118 Alexander St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF (Type or print): First: Humer — Middle: Ola — Last: Williamson

4. DATE OF DEATH: Month: April — Day: 19 — Year: 19 61

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Dec. 30, 1886 — 9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer — 10b. KIND OF BUSINESS OR INDUSTRY: Railroad — 11. BIRTHPLACE (County & State, or foreign country): Bentonville, Va. — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Caleb Leonard Williamson — 14. MOTHER'S MAIDEN NAME: Sarah Frances Bolten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: 719-05-7102 — 17. INFORMANT: Mrs. H. O. Williamson — Address: 118 Alexander St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
(b): Generalized Arteriosclerosis. — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 5, 1958 to Apr. 19, 1961 that (I) (we) last saw the deceased alive on Apr. 16, 1961, and that death occured at 7A M, from the causes and on the date stated above

22a. SIGNATURE: R. A. Bell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Apr. 20, 1961.

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M. D. — 22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 4/22/61 — 23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery — 23d. LOCATION (City, town or county): Hagerstown (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Rest Haven Funeral Chapel — ADDRESS: Hagerstown, Md. — 25a. RECEIVED BY REGISTRAR DATE: APR 24 61 — 25b. REGISTRAR'S SIGNATURE: Chester L. Rowe

Wm. G. Hart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4915 303 04953

M

1. PLACE OF DEATH a. COUNTY: Washington — MARYLAND

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hagerstown

c. LENGTH OF STAY IN 1b: 19 Yrs

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE: Maryland b. COUNTY: Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 59 West Side Ave

d. STREET ADDRESS: 59 West Side Ave

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HENRY Last WILSON Jr

4. DATE OF DEATH Month April Day 5 Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 6 1887

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Lanoconing Garrett Co

12. CITIZEN OF WHAT COUNTRY?: USA

I

13. FATHER'S NAME: William Wilson

14. MOTHER'S MAIDEN NAME: Sarah Jane Pooley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-09-7850

17. INFORMANT Address: Mrs Viola S. Wilson 59 West Side Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Hagerstown Md.

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immed.

DUE TO (b): General arteriosclerosis and — 10 years

DUE TO (c): Coronary Thrombosis.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

1201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prostate hypertrophy, benign

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 12/30/60 19___, to 4/5/61 19___, that (I) (we) last saw the deceased alive on 3/29/61 19___, and that death occurred at 9:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Edward W. Ditto III, M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 4/5/61

22c. PHYSICIAN'S NAME (Type): Edward W. Ditto III, M. D.

22d. ADDRESS: 217 West Washington Street

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/8/61

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town, or county) (State): Hagerstown Wash Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR DATE: APR 11 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4916

CERTIFICATE OF DEATH

Reg. Dist. No. 14004

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 3 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Garlock Memorial Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 938 Mulberry Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Wingert

4. DATE OF DEATH: Month: April — Day: 1, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/15/1879

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Greenwood, Franklin Co.,

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tilman Talbert

14 MOTHER'S MAIDEN NAME: Roseanna Bohn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: John D. Wingert, 325 Fairview Ave., Waynesboro Pa.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO (b): Acute Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 week

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Arteriosclerotic Heart Disease — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19, to 4/1/61, 19, that I last saw the deceased alive on 3/30/61, 19, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Young M.D. — ADDRESS (Street, city or town, state): 148 N. Potomac St. — DATE SIGNED: 4/3/61

PHYSICIAN'S NAME (Type): S. EARL YOUNG M.D. Hagerstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4/4/61

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d LOCATION (City, town, or county) (State): Waynesboro, Franklin Co., Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Walter Y. Stover, Waynesboro Pa

24a. REC'D BY REGISTRAR — DATE: APR 5 '61

24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4917 04905

1. PLACE OF DEATH
a. COUNTY: WASHINGTON — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAGERSTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. Co. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL
d. STREET ADDRESS: KEEDYSVILLE MD. R.1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First INFANT Middle WYAND Last
4. DATE OF DEATH: Month APRIL Day 19 Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: APRIL 18 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days ONE IF UNDER 24 HRS: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): HAGERSTOWN WASH. Co. MD. U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: DAVID WYAND
14. MOTHER'S MAIDEN NAME: KATHLEEN HUFFER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: NONE
17. INFORMANT Address: DAVID WYAND KEEDYSVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Congenital Heart disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 7545

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-18-1961, to 4-19-1961, that (I) (we) last saw the deceased alive on 4-19-1961, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: H. Secondari M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Joseph Secondari, M. D.
22d. ADDRESS: 21 North Main St. Boonsboro, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: APR. 21. 1961
23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
23d. LOCATION (City, town, or county) (State): KEEDYSVILLE MD. R.1

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John N. East BOONSBORO MD
25a. REC'D BY REGISTRAR DATE: APR 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1202X-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4918 Item 12 Film G266 5/1/61 3WK 04906

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY Washington MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown
d. STREET ADDRESS 1001 Security Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Rudolph Middle --- Last Yonger
4. DATE OF DEATH Month April Day 20 Year 1961
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH December 10, 1891
9. AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance
10b. KIND OF BUSINESS OR INDUSTRY Cement Corp.
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Johan Yonger
14. MOTHER'S MAIDEN NAME Anna Decker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-10-6889
17. INFORMANT Address Miss Anna Yonger Hagerstown, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 36 hr
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertension — 3-4yr
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/17/61 19__ to 4/20/61 19__, that (I) (we) last saw the deceased alive on 4/20 1961, and that death occurred at 4:35a from the causes and on the date stated above.

22a. SIGNATURE Robert V.h Campbell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Robert V.h. Campbell
22d. ADDRESS 145 W Washington ST Hagerstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4-22-61
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
23d. LOCATION (City, town, or county) (State) Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son Hagerstown, Md.
25a. REC'D BY REGISTRAR DATE APR 24 '61
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4919 — 04967

1. PLACE OF DEATH
a. COUNTY: Washington — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
c. LENGTH OF STAY IN 1b: 44 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 622 N. Prospect St.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 622 N. Prospect St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	Edward	Zepp	April	5	1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	MARRIED ☒	May 21, 1891	69 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car man	Rail Road	Carroll Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Zepp	Elizabeth Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	705-10-8625	Mrs. C. E. Zepp	622 N. Prospect St. Hagerstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction. — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO (b): Atherosclerotic Heart Disease — Several years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 24, 1961 to Apr. 5, 1961, that (I) (we) last saw the deceased alive on April 4, 1961, and that death occured at 3A.M. from the causes and on the date stated above.

22a. SIGNATURE: R. A. Bell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Apr. 5, 1961.

22c. PHYSICIAN'S NAME (Type): R. A. Bell, M.D. — 22d. ADDRESS: Hagerstown, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
Burial	April 7, 1961	Rest Haven Cemetery	Hagerstown	Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Rest Haven Funeral Chapel	Hagerstown, Md.	APR 10 '61	Arthur L. Kines

Wm. A. Hoyt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60